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Clinical Case Studies 3-4

FROM THE RECORDS OF THE
PITTSBURGH DIAGNOSTIC CLINIC
3509 FIFTH AVE. PITTSBURGH

FOREWORD

The object of these studies is to afford practice in the formulation of a diagnosis on the basis of the history and physical findings, together with such technical procedures, X-ray studies, and opinions of specialists as may seem to be indicated. Actual case records are used, unchanged except for the deletion of identifying names and such editing as may seem advisable for the sake of brevity and clearness.

DIRECTIONS

Proceed on the basis that each case is a patient under your own care. The general history and physical findings as printed in this supplement represent what you would learn from the first visit of the patient in your office. After studying these make up your mind as to the most likely working diagnosis and put this in writing in the space provided for "Notes", this being solely for your own reconsideration in light of later information. Select the enclosed post card correspondingly numbered with the case problem you are studying and check off on the card the special procedures which you feel are definitely indicated; do not ask for everything blindly, but for only such studies as you would order if this were your own private patient. Mail the card promptly to the Pittsburgh Diagnostic Clinic, making certain to show your name and address.

You will receive from the Clinic two packets for each case. In one, will be the information you requested, provided it is available. Study this material and make up your mind as to the final diagnosis, putting your opinion in writing on the page provided for "Notes". Then open the second packet which contains the final report made by the Clinic Staff, and follow-up information as to the patient's subsequent clinical course which serves as a check on the accuracy of the diagnosis.

It is particularly urged that you commit yourself in writing at every stage of the study because a comparison of the provisional with the final diagnosis will frequently prove most instructive.

GENERAL HISTORY

White Male Married Age 36 years

CHIEF COMPLAINT

Lack of energy.

Itchy eruption on the legs below the knees.

PRESENT ILLNESS

For the past year and one-half the patient has noticed gradually increasing lack of energy; he feels tired and "lacking in muscle tone," so that it is an effort for him to physically exert himself. There is poor appetite in the morning, which improves throughout the day so that toward evening he usually enjoys a very large meal. At occasional intervals, however, there will develop a sudden sensation of nausea immediately after eating so that he may vomit the entire meal; no constant gastrointestinal disturbances and no diarrhea or severe constipation; no urinary symptoms.

In addition to his tiredness and lack of energy, his physician has found a low blood pressure, averaging 90, for the past year. Both he and his friends have noticed a change in his appearance, this being due mostly to a slight puffiness of the face and a tendency to yellowish complexion, although there has been no true jaundice. His hands, also, feel puffy and stiff, and his fingers are larger, so it is difficult to wear a ring which was formerly comfortable. He, himself, is conscious of the fact that he thinks and speaks more slowly. There is a tendency to chilliness, especially when the weather is cool.

Two weeks ago he began to be bothered with itchiness of both legs below the knees, together with the development of peculiar localized skin lesions, appearing first as an area of redness, then itchiness, with a white center, this rapidly developing into a

blisters which showed a tendency to become larger and larger. At the present time his legs show eight or ten such lesions in every stage from the area of erythema to that of localized induration and itching and then various blisters with yellowish clear fluid, and finally the residual stage where the water has either been reabsorbed or mechanically discharged, with the loose, dead skin lying close to the under surface. In relation to this it may be significant that the patient has suffered with the Fall type of hay fever all his life, and that just before the development of the eruption on the legs he walked through a field that was thick with ragweed in pollen.

PAST HISTORY

Recurring attacks of tonsillitis by reason of which the tonsils were removed one year ago. No rheumatism. He also had a severe influenza in 1910 while in the army, being delirious for several days and incapacitated for two or three weeks. No other acute illness. No trouble with the eyes, ears, nose or throat, except for the recurring tonsillitis noted above.

The patient has had two attacks of sudden severe cramp-like pain in the left lumbar region, developing while walking, giving rise to total incapacity, but not associated with any urinary disturbances; both attacks suggested an acute lumbago. The first attack was three years ago, as the result of which he was confined to bed for two weeks. The second attack was last April and disappeared three days after the onset. There is no aching or discomfort in the affected region between these attacks. No symptoms in the past referable to the heart, lungs, gastro-intestinal, or genito-urinary tracts.

Occupation—Teacher in the Department of Agriculture and this work takes him outside for a considerable portion of his time.

Habits—regular as to hours of eating and sleeping; no alcohol. Tobacco, very moderately.

Venereal history—negative.

Marital history—married, wife living and well; one child living and well.

Family history—negative.

PHYSICAL EXAMINATION

GENERAL

Height 67½ inches Weight 147 pounds Temperature 98°

Patient is normally developed, rather slow in his movements; seems a little listless, but there are no signs of mental depression or emotional instability. Skin is not noticeably dry, but the hair of the scalp is sparse. There is a distinct yellowish brownish pigmentation to the face, but this does not involve the skin of the body. There is also a slight, brawny, generalized subcutaneous edema, not pitting on pressure.

HEAD AND NECK

Ears—negative. Eyes—pupils are equal, react normally, associated movements normal. Mouth—teeth are well preserved, gums clean. Throat—not injected, tonsils well removed. Glands—no general enlargement; thyroid—not enlarged.

THORAX

Lungs are clear throughout.

Heart—normal size, rate is 68, regular in force and rhythm; sounds are somewhat distant, soft, but no murmurs are heard; pulse—68, regular, no abnormal thickening of vessel wall.

ABDOMEN

No masses or areas of tenderness; spleen not felt; liver to costal margin, edge not felt.

EXTREMITIES

Slight, brawny edema; reflexes are all normal, no tremor. Fingers are puffy in appearance, but there is no thickening of the joints or other abnormality. Scattered over both legs below the knees are various stages of bullous-like eruptions, varying in size from 5 to 10 mm., tending to be confluent, the earliest ones being round erythematous areas, itchy, with a white, fairly indurated center. Later ones are round circumscribed blisters, raised up, with clear yellowish contents, but no signs of inflammatory reaction about the periphery.

BLOOD PRESSURE

Systolic, 85. Diastolic, 50.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination only.

MY REVISED DIAGNOSIS

Taking into consideration reports requested on special studies.

GENERAL HISTORY

White

Female

Married

Age 58 years

CHIEF COMPLAINT

Recurring cramp-like pains in the midepigastrium.

Vomiting of blood and passage of tarry stools.

PRESENT ILLNESS

Onset about two months ago when she began to be bothered with severe, recurring, cramp-like pains high up in the midepigastrium, associated with sensations of gas, eructations of sour burning material and occasional vomiting. When she would vomit the material was very sour and on several occasions contained small amounts of moderately bright blood. There was also a bad taste in the mouth and a bad, nauseating taste to the material she would eructate. She noticed at occasional intervals that her stools were "black as coal." The cramp-like pains were more or less constant, but were accentuated if she took anything into the stomach, even water, with the single exception of milk of magnesia which would accord her temporary relief. When the stomach was empty the pain was less marked, but was not entirely absent. These sensations continued becoming more and more marked until five days ago when, while cooking her noon meal, she suddenly became faint and finally fainted. She revived almost immediately, but felt very weak. She noticed that the severe pain in the midepigastrium had disappeared, and this has not recurred to any noticeable degree up to the present time. The next day after she had fainted, she vomited a rather large amount of coffee-ground material, and since then her stools have constantly been black and tarry. She feels very weak. In regard to weight, the information is unsatisfactory. There has apparently been a moderate loss of weight in the past year, but

she does not know exactly how much this weight loss is, basing her estimate merely on the fact that her clothes are looser than they were a year ago. She thinks that there has not been much change in weight in the past two months.

There are no other definite symptoms except the arthritis which has bothered her for the past nine years, described in detail under Past History.

PAST HISTORY

In general, the patient has always been well, very strong, and vigorous, both physically and mentally. Nine years ago she developed a very severe generalized arthritis, involving the hands and feet to the greatest extent, but also all the other joints of the body, including knees, hips, back, neck, and jaws. The arthritis at first was accompanied by swelling, redness, and very severe constant pain so that she had difficulty moving around or lying and suffered constantly. Within a few months after the development of the arthritis, she was treated at a local hospital by foreign protein injections. She then went to Germany where a similar treatment was carried out and also heat and massage. She returned to this country, again went to a local hospital where she underwent a tonsillectomy, following this by a short period of hydrotherapy; there has been no consistent medical treatment since that time, but the arthritis has apparently been more or less stationary. There is a constant, rather dull discomfort, involving particularly the hands and feet, but also the other joints, especially the neck and back, this being a severe ache and stiffness, especially when she does not use them, such as during the night. After sleeping for about an hour she will awaken with this stiffness and discomfort. There has been a progressive distortion of the joints of the fingers and toes so that they are almost now immovable, distorted, somewhat swollen and thickened.

Previous to the development of the arthritis she was quite well. Thirty-one years ago she underwent a pelvic repair;

twenty-two years ago she was operated upon for rectal fistula, since when there has been no recurrence of any such signs. She had pneumonia twenty years ago; otherwise, past history is quite negative.

No particular symptoms referable to the eyes, ears, nose, throat, heart, lungs, gastro-intestinal, or genito-urinary tracts, except those outlined above.

Marital history—married 37 years; three children, ages 36, 33, and 26, all living and well. Had two or three miscarriages each at six and seven months, between the second and third children; no pregnancy since the third child. Husband is living and well.

Habits—regular as to hours of eating and sleeping.

Family history—father suffered with chronic rheumatism and finally died of so-called “rheumatic heart.” Otherwise, family history is negative.

PHYSICAL EXAMINATION

GENERAL

Height 63 inches Weight 145 pounds Temperature 98.6°

Patient is of the robust, stocky, short-necked type; she appears somewhat pale and there is a very slight yellowish tint to the skin; no cyanosis, jaundice, eruptions, or evident dyspnea. Patient does not present the usual appearance of cachexia. The skin is of normal texture and the subcutaneous fat is well preserved.

HEAD AND NECK

Ears—negative. Eyes—pupils are equal, react normally, associated movements normal. Mouth—teeth all out except for the lower front; gums are clean. Throat—tonsils well removed. Glands—no supraclavicular nodes; no general enlargement. Thyroid—not enlarged.

THORAX

Lungs are clear throughout.

Heart—moderately enlarged down and to the left; point of maximal impulse is in the fifth interspace, just in mammillary line; rate is 90, regular in force and rhythm. Sounds are rather blurred, somewhat indistinct, but no murmurs can be heard. Over the aortic area the aortic second is rough and accentuated, but there is no definite murmur. Pulse—90, regular, no abnormal thickening of vessel wall.

ABDOMEN

There is distinct, persistent tenderness high up in the midepigastrium, making deep palpation rather unsatisfactory; palpation is not attempted with great pressure because of the history

of a recent gastric hemorrhage; no mass can be felt; spleen is not felt; liver is palpable one finger's breadth below the costal margin, but it is of normal consistency and no nodules can be made out; no tenderness in the liver region. No tenderness over the lower abdomen, although the patient complains of vague soreness of the entire intestinal tract.

EXTREMITIES

No edema; there is distortion, thickening, and some limitation of movement of all the joints of the fingers and toes; no tenderness or local heat. Some limitation of motion in the larger joints, but no great thickening and no signs of any local fluid. No tremor.

BLOOD PRESSURE

Systolic, 185.

Diastolic, 90.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination only.

MY REVISED DIAGNOSIS

Taking into consideration the reports requested on Special Studies.